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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on observation, interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 3 of 37 residents reviewed (Resident #16, Resident #34, and Resident #429). This deficient practice was evidenced by the following: 1. On 11/7/24 at 11:08 AM, the surveyor observed Resident #16 to be out of bed, in a wheelchair, and in the dayroom participating in activities. On 11/8/24 at 1:10 PM, the surveyor observed Resident #16 in a wheelchair, outside smoking with staff supervision. A smoking apron was visible on Resident #16's lap. A review of the Admission Record face sheet (an admission summary) reflected Resident #16 had diagnoses which included but not limited to: Alzheimer's disease. A review of the Admission MDS, an assessment tool dated 4/23/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderately impaired cognition and Section J1300 was coded no for current tobacco use. On 11/13/24 at 11:00 AM, the surveyor interviewed the MDS Coordinator and asked about the current tobacco use coding, she stated oh gosh, I see it, it was not coded. It was missed. 2. On 11/7/24 at 10:40 AM, the surveyor observed Resident #34 to be out of bed, sitting in a wheelchair in the room. On 11/8/24 at 12:38 PM, the surveyor was informed by staff that Resident #34 was out to dialysis. A review of the Admission Record face sheet reflected that Resident #34 had diagnoses which included but not limited to; end stage renal disease (kidney disease), diabetes, and dependence on renal dialysis (a machine that removes waste products and excess fluid from the blood). A review of the annual MDS, dated [DATE], revealed a BIMS score of 14 out of 15, which indicated intact cognition, and Section O0110 question J1 was not coded for dialysis while a resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the individual comprehensive care plan (ICCP) included a focus area dated 3/22/18 and revised 9/11/23, that the resident had a potential for complications due to hemodialysis; a focus area dated 7/18/18 and revised on 9/11/23 regarding the resident's dialysis schedule; and a focus area dated 3/23/18 and revised 7/18/24 that the resident has end stage renal disease on hemodialysis with an increased protein need. On 11/13/24 at 11:03 AM, the surveyor interviewed the MDS Coordinator and asked about the dialysis coding, she stated, I didn't see a note at that time. 3. On 11/07/24 at 11:34 AM, the surveyor observed Resident #429 in the dayroom. A review of the Admission Record face sheet reflected that Resident #429 had diagnoses which included but not limited to; moderate dementia with behavioral disturbance. A review of the electronic medical record indicated that on 10/30/24 at 6:38 PM Resident #429 was noted cursing on and off, kicking and throwing objects. On 10/31/24 at 10:54 PM, the Resident #429 was noted to be kicking, pushing, throwing objects, and cursing on and off. A review of the Admission MDS, dated [DATE], revealed a BIMS of 0, indicating severe cognitive impairment and section E200 and E300 were coded to reflect no behavior symptoms. On 11/14/24 at 12:28 PM, the surveyor interviewed the MDS Coordinator, who indicated that the MDS assessments should be accurate. When asked about the above mentioned MDS and the coding of behaviors, she stated that she would check and get back to the surveyor. On 11/14/24 at 1:21 PM, the surveyor interviewed the MDS Coordinator in the presence of the survey team. She stated she did not code the resident's behaviors and it should have been done. A review of an undated facility policy Resident Assessment Instrument MDS included: 2. The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to gather other pertinent data. 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 8. If an error is made when completing the MDS, the error will be corrected when discovered. N.J.A.C 8:39-11.1

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48422 Based on observation, interview, and record review, it was determined that the facility failed to ensure the necessary respiratory care and services were provided in a manner to prevent the spread of infection for 1 of 4 residents (Resident #4) reviewed for respiratory care. This deficient practice was evidenced by the following: On 11/7/24 at 10:57 AM, the surveyor observed Resident #4's nebulizer machine (an electric machine that converts liquid medication to a fine mist) on the dresser in their room, surrounded by personal items. The tubing attached to the nebulizer was not labeled or dated. Additionally, the nebulizer mask was not covered and was left exposed to the air. The exterior of the nebulizer machine showed yellowish stains and a brown fuzzy debris accumulation on the surface. On 11/12/24 at 12:09 PM, the surveyor observed the same nebulizer machine. The stains on the exterior of the machine and the brown fuzzy debris covering the surface remained present. The nebulizer mask was uncovered and exposed to the air. On 11/13/24 at 9:51 AM, the surveyor interviewed Resident #4 about the care and maintenance of their nebulizer equipment. The resident informed the surveyor that the staff changed the tubing on a weekly basis. However, the resident also stated that they had never seen staff clean the nebulizer machine and acknowledged that the machine was not clean. The stains on the exterior of the machine and the brown fuzzy debris on the surface were still present, and the nebulizer mask remained uncovered and exposed to air. A reviewed the Admission Record, which reflected that Resident #4 was admitted to the facility with medical diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a lung disease that makes breathing difficult), acute on chronic systolic heart failure, and cardiomyopathy (a disease of the heart muscle making it difficult to pump blood). A review of the Minimum Data Set (MDS), an assessment tool, dated 9/5/24, revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score 14 out of 15, which indicated intact cognition. A review of the physician orders for Resident #4, revealed a physicians order dated 11/8/24 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally three times a day for shortness of breath (SOB) for five days. On 11/13/24 at 12:51 PM, the surveyor interviewed the Unit Manager Licensed Practical Nurse (UMLPN). The UMLPN described the facility's process for changing the nebulizer tubing and masks, noting that this occured every Tuesday. The UMLPN stated the tubing and mask should be dated and placed in a bag after use, the mask should be cleaned after each use and stored in a bag. The UMLPN acknowledged that there was no established procedure for cleaning the exterior of the nebulizer machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1:02 PM, the surveyor interviewed the Infection Preventionist (IP). The IP explained that the nebulizer tubing and masks were changed weekly, typically on Tuesday nights for the entire building. The mask should be dated and placed in a bag after use. She further explained the nursing staff was responsible for cleaning the nebulizer masks after each use and allowing them to air dry and ensuring that the masks were returned to the bag once cleaned. The IP further clarified that the nebulizer machines should be wiped down daily by nursing, with the final cleaning should be performed by housekeeping. During the interview, the surveyor made the IP aware of the above mentioned observations. The IP responded that this should not be like that and emphasized that the equipment should have been properly cleaned and maintained to prevent any risk of contamination. On 11/13/24 at 1:08 PM, the surveyor and the IP entered Resident #4's room to observe the nebulizer equipment. The resident was in their room at the time. The nebulizer mask was found to be bagged. Resident #4 informed the surveyor and the IP that the nurse had just been in the room about five minutes prior, changed the tubing, and placed the mask into the bag. On 11/13/24 at 1:13 PM, the surveyor and the IP went to the nurses' station, where the Unit Manger Licensed Practical Nurse (UMLPN) and the Licensed Practical Nurse (LPN), who was responsible for Resident #4's care, were present. The LPN verified that she had been in Resident #4's room and changed the tubing, and bagged the mask prior to the surveyor and the IPs observation. On 11/13/24 at 1:16 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment with a revision date of 8/1/24. Under the Policy Interpretation and Implementation section, the policy included: Respiratory-Tubing/Equipment (nebulizer chamber) changed weekly. In between use items will be stored in a plastic bag. NJAC 8:39-27.1 (a)

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F 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.

48422

Compliant #: NJ169617

Based on observation, interviews, review of the medical record and other pertinent facility documents, it was determined that the facility failed to ensure that a resident received preferred and accurate meal items at lunch service and in accordance to what was indicated on the meal ticket. This deficient practice occurred for 1 of 8 residents observed during dining service (Resident #147), and was evidenced by the following:

On 11/08/24 at 12:29 PM, during the lunch meal service, the surveyor observed Resident #147 sitting in a wheelchair in their room. The resident was accompanied by a family member who stated that the resident consistently received incorrect meals. The resident stated that he had ordered pork chops but was served fish instead. The resident confirmed he has previously informed the staff that he did not like fish.

A review of the Admission Record (an admission summary) included that the resident was admitted with diagnoses that included but were not limited to; cerebral infarction (stroke), essential hypertension, Alzheimer's disease, unspecified dementia, psychotic disturbance, mood disturbance and anxiety.

A review of the Quarterly Minimum Data Set (MDS), a tool that facilitates the management of care, dated 10/03/2024, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15. This score indicated a moderate cognitive impairment.

A review of the physician orders (PO) for Resident #147, dated 11/08/2024, revealed a PO for: No Added Salt (NAS), regular texture, thin consistency diet.

A review of the nutrition care plan, dated 10/2/24, did not reflect any documented food preferences.

On 11/08/24 at 12:42 PM, the surveyor observed the resident's lunch tray in the presence of Licensed Practical Nurse (LPN) #1 and the Unit Manager LPN (UMLPN) #1.

The lunch tray contained a fish fillet with lemon dill sauce, rice pilaf, oriental zucchini, skim milk, and juice. A review of the meal ticket on the tray indicated the resident should have received herb breaded pork chops, rice pilaf, braised cabbage, fruited yogurt, whole milk, juice, and coffee. LPN #1 and UMLPN #1 acknowledged that the lunch tray items did not match what was indicated on the resident's meal ticket.

On 11/12/24 at 10:01 AM, the surveyor interviewed the Food Service Director (FSD). The FSD stated that the kitchen ran out of pork chops, which was an alternate and popular meal choice that day. He stated that several residents had requested to change their orders from fish to pork chops and as a result, the facility ran out of pork chops. In addition, the FSD acknowledged that the facility should have notified the resident of the substitution and stated that the staff was in a rush.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:40 AM, the surveyor interviewed the FSD, in the presence of a second surveyor. The surveyor inquired why Resident #147 did not receive yogurt for lunch on 11/08/24. The FSD could not explain why fruit yogurt was indicated on the meal ticket but the resident did not receive it. He further stated that resident's food preferences should have been accommodated. The FSD acknowledged the importance of honoring resident's meal preferences was because it was a resident right. The FSD also stated that the Caller/Checker position at the end of the tray line was responsible to ensure meal tray accuracy and that he was ultimately responsible for the accuracy of this process. On 11/14/24 at 12:04 PM, the surveyor interviewed the Registered Dietitian (RD), in the presence of a second surveyor. The RD stated that if a resident did not receive the meal they requested or preferred consistently, this could place the resident at nutritional risk as residents are less likely to eat meals they do not want. A review of the facility-provided Week-At-A-Glance menu, which is used for residents to make their meal selections, indicated that Resident #147 had selected herb breaded pork chops, braised cabbage, rice pilaf, whole milk, juice, and coffee for their lunch meal on 11/08/2024. The meal served to the resident did not match their selection, as the tray contained fish fillet with lemon dill sauce, rice pilaf, and other items inconsistent with their choice. On 11/13/24 at 1:16 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled Resident Food Preferences, with a revision date of 8/1/24. Under the Policy Interpretation and Implementation section, the policy included: The resident's clinical record (including orders, care plans, or other appropriate locations) will document the resident's likes and dislikes, as well as any special dietary instructions or limitations, such as altered food consistency and caloric restrictions. The LNHA also provided the surveyor with a facility policy titled Meal Distribution and Tray Line Policy, with a revision date of 8/1/24. This policy included the following: Tray Assembly: Meals must be accurately assembled according to each resident's dietary plan, which includes special diets, allergies, and preferences. Each tray should be checked against the resident's meal ticket for accuracy. Quality Control: Supervisory staff will review trays for presentation and completeness before leaving the kitchen, ensuring that each resident receives their correct meal. NJAC 8:39 17.4 (a)1

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 40042 Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to a.) ensure a resident received liquids in the appropriate consistency at bedside in accordance with physician orders and b.) follow the guidance on the resident's individualized comprehensive care plan. This deficient practice was identified for 1 of 3 residents reviewed for nutrition (Resident #60). This deficient practice was evidenced by the following: On 11/13/24 at 10:40 AM, two surveyors observed Resident # 60 in bed awake and alert. The surveyors observed a 16-ounce (oz.) water cup with a straw on the bedside table which was not in the resident's reach. The resident was unable to state whether he/she had a thickened liquid diet order. A review of the Admission Record (an admission summary) reflected the resident had diagnoses that included but were not limited to: cerebral infarction (stroke), asthma and dementia. A review of a Quarterly Minimum Data Set, a tool used to facilitate the management of care, dated 10/18/24, reflected the resident had a Brief Interview of Mental Status of 12 out of 15, which indicated the resident had a moderately impaired cognition. The MDS also indicated that the resident had a diagnosis of dysphagia and was on a mechanically altered diet that required a change in texture of food or liquids such as pureed food or thickened liquids. A review of the Order Summary Report reflected the resident had a physician's order (PO) for a Honey consistency diet dated 11/6/24. A review of the comprehensive care plan reflected the resident received honey thickened liquids with a revised date of 11/9/24. A review of a Nurse Practitioner's progress note dated 11/7/24, reflected the resident had chronic oropharyngeal dysphagia (difficulty swallowing) related to advanced dementia. It also reflected the resident had a modified barium swallow (a swallowing test) on 11/6/24, which indicated the resident aspirated (inhaled) with liquids and required thickened liquids. A review of a Speech Language Pathologist (SLP) treatment progress note, dated 11/11/24, reflected the resident had a diagnosis of oropharyngeal dysphagia and required honey thick liquids. It also reflected that nursing was educated on the resident's downgrade to honey thick liquids and verbalized understanding. A review of the modified barium swallow results, dated 11/6/24, reflected a recommendation for honey thick liquids. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at approximately 10:40 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) #1 in the presence of a second surveyor, who stated that the resident was on a honey thick liquid diet. In addition, she stated that she prepared thier bedside water earlier in the day. LPN #1 demonstrated how she prepared the honey thick water at the medication cart in the presence of two surveyors. She used preportioned powdered thickener in packets. In total, she mixed 16 oz. of water from a gallon jug with three thickener packets. She stated the longer it sat the thicker the fluid would become. The surveyor reviewed the packet instructions with LPN #1, which indicated two packets should have been used for every four oz. of water to achieve a honey thick liquid consistency. LPN #1 stated that she determined the appropriate consistency by visual assessment. On 11/13/24 at 10:56 AM, the surveyor interviewed the SLP, in the presence of a second surveyor. The SLP reviewed the packet instructions and verified that for every four oz. of water, two packets were required to achieve a honey thick liquid consistency. In addition, she stated that the kitchen had prethickened nectar and honey thick liquids. At that same time, LPN #1 showed the SLP and surveyors a four oz. portioned lemon-flavored nectar thick water and stated there was no prethickened honey thick water on the unit and could not state whether she contacted the kitchen for it. On 11/13/24 at 11:01 AM, the SLP and two surveyors went to the resident's room to observe the bedside water. The SLP lifted the 16 oz. clear plastic cup of water and acknowledged that it (the liquid and the powder) was separated. The bottom was cloudy, and the top was clear thin liquid. She stated, that happens a lot with the powder we use. She further stated the resident recently had a swallowing test. On 11/13/24 at 11:10 AM, the SLP mixed the contents of the cup with the straw, in the presence of two surveyors. She acknowledged that the liquid was not a honey consistency and further stated I don't think this was ever honey thick. She also acknowledged that according to the thickener packet instructions, eight packets were required to thicken 16 oz. of water to a honey thick consistency. On 11/13/24 at 11:16 AM, the surveyor interviewed the Registered Dietitian (RD) and the Regional Food Service Director (RFSD), in the presence of a second surveyor. Both stated that the kitchen had prethickened portioned honey thick juice, milk and water. The RFSD showed a full unopened case of four oz. lemon flavored honey thick water to the surveyors. On 11/13/24 at 11:31 AM, the surveyor gave the resident's 16 oz. water cup to the RFSD to assess. He stated that the fluid was not thick enough to be a nectar or honey consistency. He stated that two packets of thickener were required for every four oz. of water to achieve a honey thick liquid consistency. He further stated that the cup had too much water verse packets. At this same time, the RD also stated that the liquid was not thick, and both acknowledged the liquid was not honey thick. On 11/13/24 at 12:35 PM, the surveyor interviewed Director of Nursing (DON), in presence of the survey team. She stated that the kitchen had prethickened liquids and in the event they did not the nursing staff would have to use the powdered thickener. The DON stated that the nurses were clinically astute (able) to determine liquid consistencies visually. She stated that she would have expected the nurse to contact the kitchen for prethickened liquids if they were not available on the unit. On 11/13/24 at 12:46 PM, the surveyor provided the residents 16 oz. cup of liquid to the DON to observe. She stated, this is pretty thin, not a honey consistency. She further stated the nurse did not follow the PO. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:15 AM, the SLP provided an undated document to the surveyor in presence of the survey team. The document titled Liquid Consistencies indicated that the definition/description of a honey consistency were Liquids can be poured but are very slow. Liquids will require a thickening agent to reach this consistency. Food slowly drips in dollops (or blobs) off the end of a spoon. A review of the facility policy Thickened Liquids, Fluid Restrictions and NPO [nothing by mouth] dated 8/2024, included Assure that there is no water pitcher or other thinned liquids at the resident's bedside who is ordered thickened liquids . A review of the undated facility policy Care Plans, included that it reflected treatment goals and objectives. NJAC 8:39-17.4(a)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40042 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 11/07/24 at 9:39 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and a second surveyor. The following was observed: 1. Two top reach in refrigerators that held milk. The refrigerator on the right stored four- and eight-ounce milks and the refrigerator on the left stored gallon milk. Both had gray gaskets on the doors which had a heavy buildup of a black substance on the underside of the top gaskets. The FSD stated it was mold and needed to be cleaned. 2. In the room outside the main kitchen, the surveyor observed a windowsill next to a metal rack which stored boxes of salt and pepper packets. The sill had large amount of debris, leaves and twigs. The FSD stated that when the staff opened the window debris gets in. 3. The bread rack had multiple opened bags of bagels which had a heavy build up of a green fuzzy substance. Three bags were dated 10/25/24. One bag had six bagels and the two other bags had two bagels. A fourth bag dated 10/29/24 had four bagels. The FSD stated the Assistant FSD was responsible for rotating the bread but was not working today. The surveyor observed the designated dented can area next to the bread rack. 4. In the dry storage area, there were dented cans which were in rotation for use. The surveyor observed the following dented cans: - One #10 sized cans of stewed tomatoes - One #10 sized can of sliced potatoes The FSD acknowledged that the cans were dented and should not have been in the dry storage area. 5. The double stack convection ovens had a large build up of black debris which the FSD acknowledged and stated they needed to be cleaned. 6. The two metal shelves over the range had a heavy build up of black debris on the underside of the shelves above the cooking area. The FSD acknowledged this and stated there could be cross contamination. 7. There was a slicer (not in use) which had a soiled oven mitt stored directly on the area where sliced food would be. In addition, there was a light brown debris on the blade and base. At that time, the cook stated she had not used the slicer today. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an undated facility policy Sanitation, included that the food service area should be maintained in a clean and sanitary manner. It also included that all kitchen areas should be kept clean and free from litter and rubbish. It further included that shelves and equipment should be kept clean and the Food Service Manager was responsible for scheduling staff for regular cleaning. A review of an undated facility policy Food Storage, included food storage areas should be maintained in a clean, safe and sanitary manner. It also included that food should be rotated as delivered and a first-in, First-out method should be used. NJAC 8:39-17.2(g)